Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EDWARD WOLSKI MD
SUITE 336
2436 IH35 SOUTH
DENTON TX 76205

Respondent Name
AMERICAN GUARANTEE & LIABILITY

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-3047-01

MFDR Date Received
July 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied payment for code 97110 using 119=Benefit Maximum for this time period occurrence has been reached and 168=Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services. This is an incorrect denial reason. When we submitted documentation for preauthorization, we requested 4 units of 97530 and 4 units of 97110. I have included a copy of the preauthorization request as well as the Approval Letter from the carrier... The carrier changed our preauthorization without giving us an opportunity to agree or disagree. The carrier is in violation of Rule 134.600. On date of service 8/7/13, the carrier paid $47.14 on Code 97110 and $51.59 on code 97530. These are incorrect payments according to the DWC fee schedule. The carrier paid $206.36 on code 97530 on all other preauthorized dates of service."

Amount in Dispute: $2,370.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier's representative did not respond to the DWC060 request. A copy of the DWC060 request was placed in the insurance carrier's representative box 19 assigned to Flahive, Ogden & Latson. The DWC060 request was stamped received by Gordon Clayton with FOL Fileroom on July 25, 2013. A decision will therefore be issued based on the documentation contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2012 through October 16, 2012	97710-GP and 97530-GP	$2,370.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
   - W1 – Workers compensation state fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Did the requestor submit documentation to support that preauthorization was obtained for the disputed dates of service?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code § 134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning..."

   The requestor seeks reimbursement for CPT code 97110 rendered on July 17, 2012 through October 16, 2012. The insurance carrier denied/reduced the disputed service with denial reason code(s) "119 – Benefit maximum for this time period or occurrence has been reached," and "168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services."

   Review of the preauthorization issued by GENEX, GENEX Case # UDEBBQ (Preauthorization # 987576) dated January 7, 2013 documents that the requestor obtained preauthorization for 12 approved visits of physical therapy 3 x 4, CPT codes 97110 and 97530, with a start date of January 3, 2013 and an end date of April 2, 2013.

   The disputed services were rendered on July 17, 2012 through October 16, 2012. Review of the preauthorization letter submitted with the DWC060 request, documents that preauthorization was obtained for service dates provided between January 3, 2013 and April 2, 2013. Review of the preauthorization request documents that the preauthorization request was submitted to the insurance carrier on December 28, 2012, after the disputed dates of service. The disputed charges were therefore not preauthorized as required by 28 Texas Administrative Code § 134.600. As a result, the requestor is not entitled to reimbursement for the disputed charges.
2. Review of the submitted documentation finds that the requestor has not submitted sufficient documentation to support that preauthorization was obtained for the disputed dates of service, as a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.